Henry Delclos, DDS, PC

DENTISTRY FOR CHILDREN

We welcome your child into our practice and we will try to make his or her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in aiding us to better understand your child.

Child's Name_____Sex: _____ M or F

What is your child called (nickname)? _____ Social Security # _____

What school does your child attend?_____ Grade _____ Date of Birth _____ Weight _____

Name and age of brothers and sisters _____

Child's physician or pediatrician _____

Physician's phone _____ Family Dentist _____

Dental Insurance: Yes _____ No _____

Name of Insurance company _____

Who may we thank for referring you to our office? _____

Address if known _____

Purpose of this visit _____

Name and kind of child's pet, toy, hobby, or sport activity _____

HEALTH HISTORY	**yes**	**no**
Is your child under care of a physician now?	_____	_____
Is your child receiving any medication or drugs?	_____	_____
Is there any excessive bleeding when cut?	_____	_____
Has your child ever been hospitalized?	_____	_____
Has your child ever had surgery?	_____	_____
Is there any allergy to penicillin or other drugs? Drug reactions?	_____	_____
Are there other allergies: food –pollen -animals –dust –other?	_____	_____
Does your child have good physical coordination?	_____	_____
Are there any emotional problems?	_____	_____
Has your child ever had any lower facial trauma or trauma to the mouth?	_____	_____

Is there any other information that I should be aware of that we have not discussed? Please describe _____

_____

_____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___Anemia	___Chronic Sinus	___Hearing	___Jaw Joint-TMJ	___Rheumatic Fever
___Asthma	___Convulsions	___Heart	___Measles	___Thyroid
___Bladder	___Diabetes	___Kidney	___Mononucleosis	___Tuberculosis
___Cerebral Palsy	___Epilepsy	___Liver	___High Temperature	___Blood Products
___Chicken Pox	___Fainting	___Malignancies	___Pregnancy	___Frequent Headaches
___Hepatitis	___AIDS (HIV)	___Blood Transfusions	___Other	___Head/Neck Injury

DENTAL AND FAMILY HISTORY **yes** **no**

1. Has your child had any history of thumb sucking, finger sucking, or did he use a pacifier past age 1 ½ years? (underline condition) _____ _____

Is this a currently active habit? _____ _____

2. Is your child still feeding on the bottle or breast? If no, at what age did this stop? _____ _____ _____

3. Has your child had his or her tonsils and/or adenoids removed? _____ _____

4. Does your child have or has he/she had in the past, frequent ear and throat infections, is, or tubes in ears?_____ _____

5. Has your child had any history of hearing loss or speech problem? _____ _____

(underline and explain) _____

6. Is your child adopted? _____ _____

7. Has the mother or father had a lot of tooth decay? _____ _____

8. In your family, is there any history of malocclusions, bad bites, missing or extra teeth? _____ _____

9. Has your child ever had a space maintainer, retainer, braces, orthodontics treatment, or dental tooth movement? Explain _____ _____ _____

10. Was your child early, average, or late at getting his baby and/or permanent tooth? (underline)

11. Has your child had any unfavorable experience in a dental or medical office? (underline and explain) _____ _____ _____

12. Do you consider your child to be generally nervous or hyperactive? _____ _____

13. How does your child react to an injury? _____

14. How does your child behave around strangers? _____

15. Has your child had a toothache recently? _____ _____

16. Is your child in pain now? _____ _____

17. Has your child had previous dental treatment? When and where _____ _____ _____

	yes	no
18. Does the mother and father of child live together? If no, please explain _____	_____	_____
19. Do you use bottled or highly filtered water? Reverse Osmosis?	_____	_____

Remarks _____
_____

Texas DL# _____ Texas DL# _____

Father _____ Mother _____
Full Name Full Name

DOB _____ DOB _____

Social Security # _____ Social Security # _____

Father's Home Address _____ Phone _____
Street City State Zip Code

Father Employed _____ Cell # _____
(If self employed, state business name)

Occupation _____

Business address _____ Phone _____
Street City State Zip Code

Mother's Home Address _____ Phone _____
Street City State Zip Code

Mother Employed _____ Cell # _____
If self, state business name

Occupation _____

Business address _____ Phone _____
Street City State Zip Code

In case of emergency – Name of nearest relative or friend _____

Phone _____ Relation _____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and /or all necessary dental treatment is performed.

The signature of the parent(s) or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. I understand that responsibility for dental services provided in this office for my child are mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. Dr. Delclos will submit my insurance as a courtesy to me; however, we are an **out-of-network** provider. Regardless of what the insurance pays, I am ultimately responsible for my account balance.

I authorize your office to release information to my insurance company or any insurance company for claims processing. This consent and authorization include the use of any photographs, models, x-rays, of any part of my oral and adjacent structures for records, teaching, research, clinical or scientific study or publication with suitable anonymity.

Signed _____ Signed _____
(Parent/Guardian) (Parent/Guardian)
Signed _____ Date _____

INSURANCE INFORMATION

Name of Patient _____

PRIMARY INSURANCE INFORMATION

Insured Employee _____

Social Security Number _____ DOB _____

Employer _____

Insurance Company _____

Phone Number _____(to verify coverage)

Address _____

Group or Policy Number _____

SECONDARY INSURANCE INFORMATION

Insured Employee _____

Social Security Number _____ DOB _____

Employer _____

Insurance Company _____

Phone Number _____(to verify coverage)

Address _____

Group or Policy Number _____